

# **CARE MANAGEMENT AND SUPPORT(CM) AND CARE COORDINATION AND CARE TRANSITIONS (CC)**

Corinne Torgesen

# CARE MANAGEMENT AND CARE COORDINATION

## Care Management:

- According to The Agency for Healthcare Research and Quality (AHRQ), **Care Management** is “a promising team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively.”

## Care Coordination:

- AHRQ defines **Care Coordination** as “deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care.”

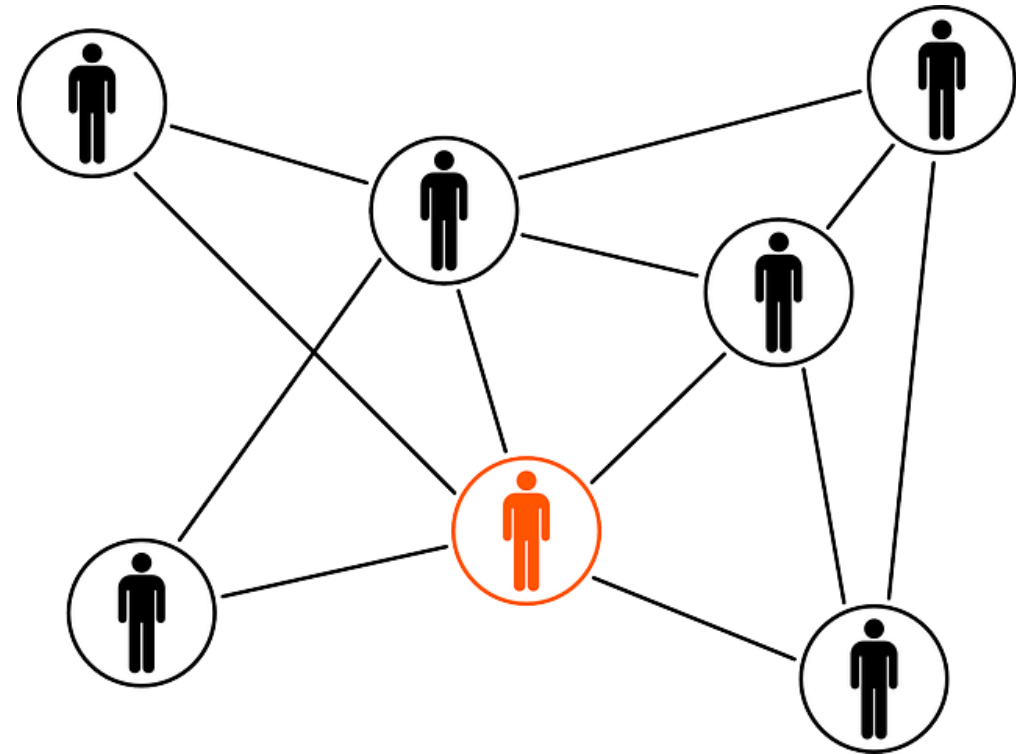
# CARE MANAGEMENT AND CARE COORDINATION

- **Care Management** is more of an episodic approach that has, according to AHRQ, “emerged as a leading practice-based strategy for managing the health of populations. It is a team-based, patient-centered approach designed to assist patients and their support systems in managing medical conditions more effectively.”

**Care Coordination** “is deliberately organizing patient care activities and sharing information among all of the participants concerned with a patient’s care to achieve safer and more effective care. It necessitates communicating the patient’s needs and preferences at ‘the right time to the right people.’”

# CARE MANAGEMENT AND CARE COORDINATION

- “**Care Management**” and “**Care Coordination**” are often used interchangeably. Both are focused on patient care, but they have differences.
- The primary care physician has more control over the **Care Management** of patients, as **Care Coordination** requires the involvement of all stakeholders, including specialty providers and healthcare facilities.
- **Care Management** can encompass **Care Coordination** activities. Similarly, **Care Coordination** is often included as part of the patient’s care management strategy.



# HOW NCQA SEPARATES CARE MANAGEMENT AND CARE COORDINATION

- **Care Management and Support (CM):**

- “The practice identifies patient needs at the individual and population levels to effectively plan, manage and coordinate patient care in partnership with patients/families/caregivers. Emphasis is placed on supporting patients at highest risk.”

- **Examples:**

- Identifying patients for care management, utilizing risk stratification (can include: those with Behavioral Health conditions, high cost/utilization, poorly controlled or complex conditions, social determinants of health).
- Referrals by outside organizations, provider referral, etc.
- Those in care management have a person-centered care plan that includes their preferences and goals, barriers to goals, self-management plan, provider recommendations, and is provided in writing to patient.

- **Care Coordination and Care Transitions (CC):**

- “The practice systematically tracks tests, referrals and care transitions to achieve high quality care coordination, lower costs, improve patient safety, and ensure effective communication with specialists and other providers in the medical neighborhood.”

- **Examples:**

- Tracking lab and imaging tests until results are available (and notifying patients).
- Systematically managing referrals (provides clinical question and pertinent patient information, and tracks referrals until specialist report is available).
- Identifying ED visits and unplanned hospital admissions (and follow up on those visits).
- Sharing clinical information with admitting hospitals.

# HOW DOES CARE MANAGEMENT AND CARE COORDINATION LOOK IN YOUR CLINIC?



- How did you establish qualifications for care management and care coordination? Or, how are you planning to establish it in your clinic?
- How has your process evolved?
- What do you wish you would have known when implementing care management and care coordination?
- What would you recommend to clinics just starting this process?
- Additional comments or questions?

# NCQA CONCEPT OVERVIEWS

## **Care Management and Support (CM)** has two Competencies

- Competency A: The practice systematically identifies patients who may benefit from care management.
- Competency B: For patients identified for care management, the practice consistently uses patient information and collaborates with patients/families/caregivers to develop a care plan that addresses barriers and incorporates patient preferences and lifestyle goals documented in the patient's chart.

**Core Criteria: (4) CM-01, CM-02, CM-04, and CM-05**

Elective Criteria Available: (6) CM-03, CM-04, CM-06, CM-07, CM-08, CM-09

## **Care Coordination and Care Transitions (CC)** has three Competencies

- Competency A: The practice effectively tracks and manages laboratory and imaging tests important for patient care and informs patients of the result.
- Competency B: The practice provides important information in referrals to specialists and tracks referrals until the report is received.
- Competency C: The practice connects with health care facilities to support patient safety throughout care transitions. The practice receives and shares necessary patient treatment information to coordinate comprehensive patient care.

**Core Criteria: (5) CC-01, CC-04, CC-14, CC-15, CC-16**

Elective Criteria Available: (24) CC-02, CC-03, CC-05 to CC-13, CC-17 to CC-21

# TIPS

- Many of the elective criteria build upon the core criteria and/or help fulfill core criteria.
- Clinics often find they are already doing some of the elective criteria. Make sure the process is formalized, and count elective criteria that are already complete towards the 25 required elective criteria.
- Care Management and Care Coordination look different in each clinic. Brainstorm how this can look in your clinic. The process does not have to stay the same as when it was first established. It can be modified based on need, process improvement, etc. This is a great opportunity to utilize the Plan-Do-Study-Act (PDSA) Cycle.



# CM-01 (CORE): CONSIDERS AT LEAST 3 OPTIONS FROM A-E WHEN ESTABLISHING A SYSTEMATIC PROCESS AND CRITERIA FOR IDENTIFYING PATIENTS WHO MAY BENEFIT FROM CARE MANAGEMENT

## Guidance:

- Practice defines a protocol to identify patients who may benefit from care management. Specific guidance includes the categories or conditions listed in A-E. A) Behavioral health conditions, B) High cost/high utilization, C) Poorly controlled or complex conditions, D) Social determinants of health, E) Referrals by outside organizations (e.g. insurers, health system, ACO, practice staff, patient/family/caregivers).

## Evidence:

- Protocol for identifying patients for care management **OR** CM-03.
- \* Practice must include **at least 3** options from A-E in their protocol for identifying patients for care management.\*

# CM-02 (CORE): MONITORS THE PERCENTAGE OF THE TOTAL PATIENT POPULATION IDENTIFIED THROUGH ITS PROCESS AND CRITERIA

## Guidance:

- Practice determines its subset of patients for care management, based on the patient population and the practice's capacity to provide services. The practice uses the criteria defined in CM-01 to identify patients who fit defined criteria. Patients who fit multiple criteria count once in the numerator.

## Evidence:

- Report
- \*Tip: It is good to start with a subset of your patient population identified that would benefit from care management. Utilize a risk-stratification method to prioritize need. **Don't stress thinking everyone identified in CM-01 will be receiving care management and therefore represented in the report for CM-02.\***

# CM-04 (CORE): ESTABLISHES A PERSON-CENTERED CARE PLAN FOR PATIENTS IDENTIFIED FOR CARE MANAGEMENT

## Guidance:

- Practice has a process to consistently develop patient care plans for the patients identified for care management. The practice involves the patient in the plan's development, which includes discussions about goals (e.g. patient function/lifestyle, goal feasibility, and barriers) and considers patient preferences.
- Care plan incorporates a problem list, expected outcome/prognosis, treatment goals, medication management and a schedule to review and revise the plan, as needed. The care plan may also address community and/or social services.

## Evidence:

- Report **OR** Record Review Workbook **AND** Patient examples.
- The practice updates the care plan at relevant visits. A relevant visit addresses an aspect of care that could affect progress toward meeting existing goals or require modification of an existing goal.

# CM-05 (CORE): PROVIDES A WRITTEN CARE PLAN TO THE PATIENT/FAMILY/CAREGIVER FOR PATIENTS IDENTIFIED FOR CARE MANAGEMENT

## Guidance:

- Practice provides the patient's written care plan to the patient/family/caregiver. The practice may tailor the written care plan to accommodate the patient's health literacy and language preference. (i.e., the patient version may use different words or formats from the version used by the practice team).

## Evidence:

- Report **OR** Record Review Workbook **AND** patient examples.
- \*Tip: The written care plan can be given to the patient in person, mailed, sent through the portal, and in any other written form that can keep patient health information confidential (i.e. Secure email).\*

# CC-01 (CORE): PRACTICE SYSTEMATICALLY MANAGES LAB AND IMAGING TESTS

## Guidance:

- Practice demonstrates how they: A) Track lab tests until results are available, B) Track imaging tests until results are available, C) Flag abnormal lab results, bringing them to the attention of the clinician, D) Flag abnormal imaging results, bringing them to the attention of the clinician, E) Notify patients of normal lab and imaging test results, and F) Notify patients of abnormal lab and imaging results.

## Evidence:

- Documented process **AND** Evidence of implementation.
- \*Tip: Practices can utilize a report, log, examples, or electronic tracking system to demonstrate how the process is met across patients for each part of the criterion.\*

# CC-04 (CORE): PRACTICE SYSTEMATICALLY MANAGES REFERRALS

## Guidance:

- Practice systematically manages referrals by: A) Giving the consultant or specialist the clinical question, the required timing and the type of referral, B) Giving the consultant or specialist pertinent demographic and clinical data, including test results and the current care plan, C) Tracking referrals until the consultant or specialist's report is available, flagging and following up on overdue reports.

## Evidence:

- Documented process **AND** Evidence of implementation.

# CC-14 (CORE): SYSTEMATICALLY IDENTIFIES PATIENTS WITH UNPLANNED HOSPITAL ADMISSIONS AND EMERGENCY DEPARTMENT VISITS

## Guidance:

- Practice should develop a process for monitoring unplanned admissions and emergency department visits and states how often monitoring takes place.
- Practice works with local hospitals, EDs, and health plans to identify patients with recent unplanned visits. Practice provides a report with the proportion of local admissions and ED visits (reported separately) to facilities where practices have an established notification exchange mechanism.

## Evidence:

- Documented process **AND** Report.
- \*Tip: The practice develops a specific process for monitoring unplanned admission and ED visits **AND** how often monitoring takes place. Determine the monitoring frequency by what works best for your practice depending on patient need, access to such reports, etc.\*

# CC-15 (CORE): SHARES CLINICAL INFORMATION WITH ADMITTING HOSPITALS AND EMERGENCY DEPARTMENTS

## Guidance:

- Practice demonstrates timely sharing of information with admitting hospitals and emergency departments. Shared information supports continuity in patient care across settings.

## Evidence:

- Documented process **AND** Evidence of implementation.
- The practice provides three examples of this exchange to meet the criteria.
- \*Tip: There is not a specific method practices must use to share information with admitting hospitals. Find the method that works best for your practice based on available resources.\* (Ideally, IHDE will help with this process in the future).



# CC-16 (CORE): CONTACTS PATIENTS FOR FOLLOW-UP CARE, IF NEEDED, WITHIN AN APPROPRIATE PERIOD FOLLOWING A HOSPITAL ADMISSION OR ED VISIT.

## Guidance:

- Practice contacts patients to evaluate their status after discharge from an ED or hospital, and to make a follow-up appointment, if appropriate.
- Practice policy defines the appropriate contact period in addition to a log documenting systematic follow-up was completed.
- Contact includes offering care to prevent worsening of a condition, clarify discharge instructions, and encouraging follow-up care.

## Evidence:

- Documented process **AND** Evidence of follow-up.
- \*Tip: The practice defines what the appropriate contact period after a discharge or ED visit is (Unless you're doing Transitional Care Management, TCM). The follow-up time period can vary depending on the reason for the patient's hospitalization or ED visit and timeliness of practice access to such reports.\*

# QUESTIONS?

Corinne Torgesen



[ctorgesen@eiph.idaho.gov](mailto:ctorgesen@eiph.idaho.gov)

208-533-3191

# RESOURCES

- <https://www.elationhealth.com/healthcare-innovation-policy-news-blog/care-coordination-v-care-management/>
- NCQA 2017 Standards and Guidelines

